DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/05/14

PRINTED: 06/02/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445240	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF RED BANK	1020 RUNYAN DR CHATTANOOGA, TN 37405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During the Recertification survey and investigation of complaints #33765, #32853, and #32516 conducted on May 19-21, 2014, at Life Care of Red Bank, no deficiencies were cited in relation to the complaints under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	This Plan of Correction constitutes not credible allegation of compliance. However, the submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal laws.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain dignity during dining for one resident (#9) of thirteen residents observed in the main dining room. The findings included: Observation on May 19, 2014, at 11:55 a.m., in the main dining room, revealed thirteen residents waiting on lunch to be served. Twelve residents had clothing protectors on. Resident #9 entered the dining room and the Dietary Manager went to the resident, while speaking to a different resident across the room, and placed the clothing protector on resident #9 without speaking to resident #9. Interview with the Dietary Manager on May 19, 2014, at 12:04 p.m., in the dining room, confirmed the Dietary Manager did not ask the	F 241	F241 1. The dietary manager, asked the resident immediately, if she wanted the clothing protector. 2. All other residents in the dining room were asked by the nursing staff if they would like a clothing protector. 3. An educational in-service regarding respect and dignity will be provided to the nursing staff by the nursing management team on 6/2/14. The nursing management team will conduct at least three weekly observation audits of the dining room practice of application of clothing protectors to assure residents are asked if they desire the use of the clothing protectors. The observation audit will occur weekly for 4 weeks then monthly for 3 months. The nurse management team will submit the audit results to the director of nursing each week.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6/9/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 resident if the resident wanted a clothing protector and did not address the resident while placing the clothing protector.	F 241	4. The director of nursing will submit the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee consisting of the medical director, director of nursing, and at least three other staff members monthly. The QAPI committee will review the results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and/or the audits reviewed for three months or until 100% compliance is achieved. The administrator will monitor the process to assure continued compliance.	6/25/14
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow physician's orders for administration of medication for one (#72) of thirty-seven sampled residents. The findings included: Resident #72 was readmitted to the facility on December 18, 2012, with diagnoses including Decubitus Ulcer Hip, Paraplegia, Diabetes, Morbid Obesity, and Rheumatoid Arthritis. Medical record review of the physician's orders dated May 2014, revealed, "Saline Nasal 0.65% - Spray bid (twice daily) two sprays both nostrils." Observation of the medication pass and interview on May 20, 2014, at 8:45 a.m., revealed the Licensed Practical Nurse (LPN) #1 did not administer Saline Nasal 0.65% Spray, ordered by the physician and listed on the Medication Administration Record (MAR). Interview with LPN #1 outside of the resident's room, confirmed the nasal spray was not administered because the medication was not on the cart and was	F 281	F281 1. The nurse offered the resident the saline nasal spray immediately. The physician was notified and discontinued the saline nasal spray. 2. All residents who are able to self-administer medication in any form were reviewed by the nursing management staff for proper documentation on 5/20/14.	

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F 281	Continued From page 2 "usually kept" in the resident's room. Further interview revealed the resident was alert and had been assessed to self administer medications. Continued interview confirmed the nurse had given medication to the resident on May 11, 2014. Further interview confirmed the LPN had documented on the MAR the medication was given May 11, 2014, but had not observed the resident administer the drug. Medical record review of the Medication Administration Record (MAR) for May 2014, revealed the medication had been documented as given twice daily for the month of May. Interview with the resident, on May 20, 2014, at 9:00 a.m., in the resident's room, with the Assistant Director of Nursing (ADON), revealed the resident had not received the medication for "some while" and had not received the medication for the month of May 2014. Interview with LPN #2 on May 20, 2014, at 9:15 a.m., at the South/West Nursing Station, confirmed when the LPN had worked the hall, the nurse had documented the medication as being given without observing the medication administered. Interview with RN Supervisor #1, at the South/West Nursing Station, on May 21, 2014, at 8:30 a.m., revealed the resident was alert and had been approved for self-administration of medications. Continued interview revealed RN #1 placed a bottle of Saline Nasal 0.65% Spray in the resident's room at the "first of the month." Continued interview confirmed the RN had signed the MAR "several times" as the medication given and had not seen the medication	F 281	3. An educational in-service was provided to the licensed staff by the nursing management staff on 05/20/2014 regarding the documentation and the application of the self-administration drug policy. Audits of the self-administration assessment of residents and compliance of the nursing staff with the dose by dose documentation will be conducted by the nurse managers at least once weekly for four weeks then monthly for 3 months. The nurse management team will submit the audit results to the director of nursing each week. 4. The director of nursing will submit the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee consisting of the medical director, director of nursing, and at least three other staff members monthly. The QAPI committee will review the results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and/or the audits reviewed for three months or until 100% compliance is achieved. The Administrator will	

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F 281 F 371 SS=F	Continued From page 3 self-administered. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to contain the hair of one of seven staff members observed; failed to maintain sanitary equipment in the food preparation area; and failed to label food in one of one walk-in coolers in the dietary department; and failed to cover food during tray service for four of four wings. The findings included: Observation on May 19, 2014, at 10:15 a.m., in the dietary department, revealed one employee in the dishwashing area wearing a visor, but no hair net. Observation on May 19, 2014, from 10:15 a.m. to 10:44 a.m., revealed the can opener blade and gears soiled with black debris, a water pan in the base of the bread warmer with a thick coating of light brown film and debris in the base of the pan,	F 281 F 371	monitor the process to assure continued compliance. F 371 1. Hairnets were immediately adorned, equipment cleaned, food labeled and food covered by the dietary staff. 2. All other observations were in compliance. 3. An educational in-service was provided on 06/09/14 regarding the policy and procedures on how to store, prepare, distribute and serve food to the dietary staff by the dietary director and executive chef. Daily inspection audits of the dietary department regarding the policies and procedures will be conducted at least 5 times weekly, for one month, then at least monthly for three months by the clinical dietician and/or the registered dietician. The audit results will be given to the executive director daily for review.	6/25/14

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F 371	Continued From page 4 and a scoop stored inside the bulk flour storage container atop the flour. Continued observation revealed the stand-up mixer splash plate and upper grill soiled with hard white and brown debris. Continued observation in the walk in cooler revealed a full pan containing fifteen uncooked rib eye steaks, unlabeled and undated, available for use; and two trays containing twenty seven fruit cups uncovered, unlabeled and undated, and available for use. Continued observation revealed a five pound plastic bag of shredded cheese opened, undated, and available for use. Review of the facility policy Associate Conduct revised January 2007, revealed, "...Food and Nutrition Services Associates wear a hair covering...at all times...cleaning schedule to include all equipment and areas to be cleaned...director of...nutrition services...monitors the...schedule...to ensure tasks are completed..." Interview with the Dietary Manager on May 19, 2014, at 10:50 a.m., in the dietary department, confirmed all foods were to be labeled and dated; hair coverings were to be worn at all times; all food preparation equipment including can openers, mixers, and water pans in the bread warmer were to be kept clean; scoops were not to be stored inside the bulk storage bins; and the facility failed to maintain sanitary conditions in the dietary department. Observation on May 19 and 20, 2014, from 12:30-1:00 p.m., during the distribution of lunch trays to the residents on four of four of the facility wings observed, revealed uncovered desserts and side dishes on the residents' meal trays.	F 371	4. The executive director will submit the audit results to the quality assurance committee, consisting of the medical director, the director of nursing and at least three other staff members monthly, for further recommendations, if needed. The executive director will monitor this process to ensure continued compliance.	6/25/14

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F 371	Continued From page 5 Continued observation revealed the meal trays were distributed from the tray cart to the resident rooms with these food items uncovered. Interview with Certified Nursing Assistant (CNA) #5 on May 19, 2014, at 12:43 p.m., in the South hallway, confirmed the pecan pie and the fruit cups were distributed to the resident rooms uncovered. Interview with CNA #6 on May 20, 2014, at 12:32 p.m., in the South hallway, confirmed the peach pie and the potato salad were distributed to the resident rooms uncovered. Interview with the Dietary Manager and Clinical Nutritionist in the dining room, on May 21, 2014, at 8:10 a.m., confirmed the facility did not cover the desserts or the side dishes during meal distribution.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain sanitary conditions for two of two dumpsters in the garbage dumpster area. The findings included: Observation on May 19, 2014, at 2:30 p.m., in the dumpster area, revealed the doors to the facility dumpsters closed. Continued observation	F 372	F 372 1. The area around the dumpster was immediately cleaned by the maintenance staff. 2. No other area was affected. 3. An educational in-service was given to the dietary and housekeeping staff by the executive director regarding keeping the area around the dumpster clean. A daily observation audit will be conducted by the director of housekeeping for one month, then at least monthly for three months to ensure compliance. Audit results will be given to the executive director weekly for review.	

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F 372	Continued From page 6 revealed multiple used latex gloves and medication dispensing cups scattered on the ground throughout the dumpster area. Continued observation revealed a plastic urinal on the ground beside the dumpster. Interview with the Dietary Manager on May 19, 2014, at 2:35 p.m., in the dumpster area, confirmed the waste was to have been contained inside the dumpsters and the facility failed to maintain sanitary conditions in the dumpster area.	F 372	4. The executive director will submit the audit results to the quality assurance committee, consisting of the medical director, the director of nursing and at least three other staff members monthly, for further recommendations, if needed. The executive director will monitor this process to ensure continued compliance.	6/25/14
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	F 441 1. The CNA's immediately sanitized their hands and the hospice nurse was informed of the isolation procedures by the nursing management staff. The boxes of clean gloves and rolls of clean trash bags were removed from the linen cart by and the scales were cleaned immediately by nursing staff. The ice chest was removed from the common area immediately by the dietary manager.	

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F 441	Continued From page 7 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, review of facility policy, and review of personnel files, the facility failed to sanitize the hands while passing the meal trays for three of three hallways; failed to ensure isolation procedures were followed for one room with two residents (#30 and #80) of thirteen isolation rooms observed; failed to properly store clean linen on four of four halls; failed to provide sanitary storage of linens in one of two linen storage closets; failed to ensure one of two bed scales were clean; and failed to ensure one of one ice chest was not contaminated in the main dining room. The findings included: Observation on May 19, 2014, at 12:30 p.m., in the North hallway, revealed the following: Certified Nursing Assistant (CNA) #1 was passing meal trays to the residents in their rooms.	F 441	2. During the survey all other hand washing observations were found to be in compliance and all other isolation rooms were being properly utilized. Linen carts were inspected and items removed by the nursing management staff during the survey. No other scales were affected. All other ice chest use were in compliance. 3. Educational in-services were conducted to staff on 06/02/2014 regarding the hand washing policy and procedure, the policy and procedure for isolation rooms, clean linen storage, bed scale cleaning and ice machines by the nursing management staff. At least five hand washing observation audits, isolation rooms audits, clean linen storage, bed scale cleaning audits will be conducted by the nursing management team weekly for 4 weeks then monthly for three months. The results of the audits will be reported to the director of nursing weekly. 4. The director of nursing will submit the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee consisting of the medical director, director of nursing, and at least three other staff members monthly. The QAPI committee will	

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F 441	Continued From page 8 Continued observation revealed CNA #1 removed a meal tray from the food cart and entered room #214. Continued observation revealed CNA #1 took the tray into the room and placed it on the overbed table, assisted with the meal set-up, and exited the room without cleansing or washing the hands. Continued observation revealed CNA #1 removed a meal tray from the food cart, gathered a clothing protector, and entered room #219 with the food tray. Continued observation revealed CNA #1 placed the clothing protector on the resident who was lying in the bed, and secured it at the back of the resident's neck. CNA #1 continued to provide tray set up to include taking the lids off the food items, picked up the utensils, and used the knife to spread the butter on the bread on the meal tray. Continued observation revealed CNA #1 did not cleanse or sanitize the hands after leaving room #219. Continued observation revealed CNA #1 removed a food tray from the food cart and took it into room #218. Observation revealed CNA #1 entered the room without cleansing or sanitizing the hands; removed the call light from the resident's bed and placed it on the bedside table; pulled the over bed table toward the resident and placed the tray on the table; removed the lids from the drinks, opened the salt and pepper packets and sprinkled the condiments on the food. Continued observation revealed CNA #1 exited the room without cleansing or sanitizing the hands. Interview with CNA #1 in the North hallway on	F 441	review the results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and/or the audits reviewed for three months or until 100% compliance is achieved. The administrator will monitor the process to assure continued compliance.	6/25/14

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F 441	Continued From page 9 May 19, 2014, at 1:04 p.m., confirmed the hands were not cleansed or sanitized between delivering and setting up meal trays for the residents. Observation on May 20, 2014, in the North hallway at 12:28 p.m., revealed the following: CNA #7 entered room #216 with the meal tray. Continued observation revealed CNA #7 set up the meal tray for the resident, including removing the lids from the drinks. While removing the straw from the wrapper, CNA #7 touched the straw with ungloved hands and placed the straw in the juice. Further observation revealed CNA #7 adjusted the resident's left foot in the wheelchair; moved the over bed table toward the resident; and while holding the cup and securing the straw with the ungloved hand, offered the juice to the resident. Resident #30 was admitted to the facility on October 3, 2008, and readmitted to the facility on July 12, 2013, with diagnoses including Urinary Tract Infection, Escherichia Coli, Congestive Heart Failure, Urinary Incontinence, Depressive Disorder, Multiple Myeloma, and Alzheimer's Disease. Medical record review of the Physician admission orders dated April 30, 2014, revealed, "...Contact Isolation for ESBL (Extended Spectrum Beta Lactamases) in urine..." Observation on May 19, 2014, at 12:52 p.m. in resident #30's room, revealed Hospice Nurse #1 was in the resident's room, wore gloves and assessed the resident's skin, obtained vital signs, and listened to the resident's heart and lung sounds while at the resident's bedside. Continued	F 441		

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F 441	Continued From page 10 observation revealed the resident's room was designated by a sign and equipment as an isolation room. Continued observation revealed the Hospice Nurse was not wearing a gown/protective apparel as appropriate for a resident on contact isolation. Resident #80 was admitted to the facility on March 2, 2007, and readmitted to the facility on January 9, 2014, with diagnoses including Urinary Tract Infection, Escherichia Coli, Dysphagia, Diabetes, Hypertension, Toxic Encephalopathy, Sepsis, Methicillin Resistant Staphylococcus Aureus, and Depressive Disorder. Medical record review of the Physician admission orders dated January 9, 2014, revealed, "...Contact Isolation-ESBL (Extended Spectrum Beta Lactamases)..." Observation on May 19, 2014, at 12:52 p.m., in the resident's room, revealed Hospice Nurse #1 assessed resident #80's roommate (resident #30) wearing gloves. Further observation revealed Hospice Nurse #1 removed gloves from the hands and placed gloves in the trash can in the room. Continued observation revealed Hospice Nurse #1 went to the right side foot of resident #80's bed with the ungloved hands and touched the sheets on the resident's bed, repeatedly, while talking with resident #80's family member in the room. Further observation revealed Hospice Nurse #1 placed both hands in jacket pockets while standing at the foot of the bed. Continued observation revealed Hospice Nurse #1 entered the bathroom of the resident's room, then went into the hallway. Further observation revealed the resident's room was designated by a sign and equipment as an isolation room. Continued	F 441		

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F 441	Continued From page 11 observation revealed the hospice nurse was not wearing gloves and a gown/protective apparel, as required, for a resident on contact isolation. Review of the facility's Transmission-based precautions and isolation procedures last revised 7/18/2011, revealed "...Transmission-based precautions are used in addition to standard precautions for residents with suspected or confirmed infectious conditions. Residents are placed on appropriate transmission-based precautions until the condition has been ruled out or the criteria for removal from isolation have been met...Isolation procedures may be implemented to prevent the spread of infection from resident to resident to health-care worker or from health-care worker to resident...Central to the success of these procedures is the selection of the proper equipment and the adequate training of those who use it...Contact precautions gloves-change gloves after contact with infectious material. Gowns/protective apparel-if contact with infectious material is anticipated..." Review of the facility's Hospice Agreement revealed "...2.7 Qualifications of personnel...have received training and will be provided with the necessary equipment and supplies to meet infection control guidelines issued by the Occupational Safety and Health Administration and the Centers for Disease Control..." Review of the Official Transcript of Hospice Nurse #1 revealed Hospice Nurse #1 received training on infection control, hand hygiene, bloodborne, standard precautions, airborne/contact/droplet precautions, and personal protective equipment on August 15, 2013.	F 441		

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F 441	Continued From page 12 Interview with Hospice Nurse #1 on May 19, 2014, at 12:54 p.m., in the hallway outside the resident's room, confirmed the nurse failed to use personal protective equipment. Continued interview confirmed the nurse failed to follow contact isolation precautions per facility policy. Interview with the Assistant Director of Nursing on May 20, 2014, at 10:23 a.m., in the social services office, confirmed the hospice nurse was aware of the contact isolation policy's procedures. Continued interview confirmed the Hospice Nurse failed to follow the facility's isolation precautions. Observation of the North hall on May 19, 2014, at 11:00 a.m., and May 20, 2014, at 8:00 a.m., revealed an enclosed clean linen cart containing a roll of garbage bags and a box of gloves stored on and in between the stacks of clean linens. Observation of the East hall on May 19, 2014, at 11:30 a.m., and May 20, 2014, at 8:15 a.m., revealed a clean linen cart with a box of gloves, white and blue bags, perineal cleansers, and a package of incontinent briefs stored on and in between the stacks of the clean linen. Observation of the West hall on May 20, 2014, at 8:35 a.m., revealed a linen cart containing a box of gloves, white bags, and blue bags stored on and with the stacks of linen. Observation of the South hall, on May 20, 2014, at 8:40 a.m., revealed boxes of gloves, and white and blue bags stored on and with the linens. Review of the facility policy titled, Laundry Services, with a revision date of May 21, 2014, revealed, "...All clean linens should be stored and	F 441		

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F 441	Continued From page 13 transported in covered carts used exclusively for this purpose..." Interview and observation of the North hall clean linen cart, on May 21, 2014, at 8:50 a.m., with Licensed Practical Nurse (LPN) #6, confirmed the linens were not stored in a sanitary manner. Interview and observation of the clean linen cart on the South hall on May 21, 2014, at 8:56 a.m., with Certified Nursing Assistant (CNA) #2, confirmed the linens were not stored in a sanitary manner. Interview and observation on the East hall, on May 21, 2014, at 9:00 a.m., with CNA #1, confirmed the items on the clean linen cart were "usually kept there but should probably not be." Interview and observation on the West hall, on May 21, 2014, at 9:10 a.m., with the Unit Coordinator, confirmed the items were not to be stored in the clean linen cart and were not stored in a sanitary manner. Interview on May 21, 2014, at 2:00 p.m., with the Assistant Director of Nursing/Infection Control Coordinator, in the Social Services office, confirmed the facility failed to maintain clean linen storage. Observation on May 19, 2014, at 10:15 a.m., on the North East hall, revealed a linen closet with the clean linen on the shelves and packages of diapers/pads stored in the closet. Interview with Licensed Practical Nurse (LPN) #7 on May 19, 2014, at 10:15 a.m., at the North East hall linen closet, confirmed the packages of	F 441		

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F 441	Continued From page 14 diapers/pads were stored in the closet and the linen was uncovered. Observation on May 19, 2014, at 10:20 a.m., in the North hallway, revealed a bed scale stored in the hallway with the base soiled with dust and debris. Interview with the LPN #7 on May 19, 2014, at 10:20 a.m., in the North hallway, confirmed the bed scale was soiled with dust and debris. Observation on May 19, 2014, at 12:05 p.m., in the main dining room, revealed an ice chest filled with ice. Continued observation revealed one visitor opened the ice chest, held a personal glass over the ice in the ice chest, scooped ice in the personal glass, and touched the glass with the scoopin the process. Further observation revealed one resident entered the dining room and went to the ice chest, opened the ice chest and removed ice, scooped ice in a personal glass while holding the glass over the ice chest, touching the glass with the scoop in the process. Observation revealed neither person washed their hands. Interview with the Dietary Manager on May 22, 2014, at 1:10 p.m., in the main dining room, confirmed the ice chest was accessible to anyone and confirmed it was used by visitors and residents without monitoring if use resulted in contamination.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514	1. The nurse offered the resident the saline nasal spray immediately. The physician was notified and discontinued the saline nasal spray. 2. All residents who are able to self-administer medication in any form were reviewed for proper documentation in the clinical record by the nursing management staff on 5/20/14.	

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F 514	Continued From page 15 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a clinical record was accurately documented for medication administration for one (#72) of thirty-seven sampled residents. The findings included: Resident #72 was readmitted to the facility on December 18, 2012, with diagnoses including Decubitus Ulcer Hip, Paraplegia, Diabetes, Morbid Obesity, and Rheumatoid Arthritis. ... Medical record review of the physician's orders dated May 2014, revealed, "Saline Nasal 0.65% Spray bid (twice daily) two sprays both nostrils." Observation of the medication pass and interview on May 20, 2014, at 8:45 a.m., revealed Licensed Practical Nurse (LPN) #1 did not administer Saline Nasal 0.65% Spray, ordered by the physician and listed on the Medication Administration Record (MAR). Interview with LPN #1 outside of the resident's room, confirmed	F 514	3. An educational in service was conducted on 05/20/2014 regarding the documentation and the application of the self-administration policy by the nursing management staff. Audits of the self-administration assessment of residents and compliance of the nursing staff with the dose by dose documentation will be conducted by the nurse managers weekly for four weeks then monthly for 3 months. The nurse management team will submit the audit results to the Director of nursing each week. 4. The Director of Nursing will submit the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee consisting of the medical Director, director of nursing, and at least three other staff members monthly. The QAPI committee will review the results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and/or the audits reviewed for three months or until 100% compliance is achieved. The administrator will monitor the process to assure continued compliance.	6/25/14

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F 514	Continued From page 16 the nasal spray was not administered because the medication was not on the cart and was "usually kept" in the resident's room. Further interview revealed the resident was alert and had been assessed to self administer medications. Continued interview confirmed the nurse had given medication to the resident on May 11, 2014. Further interview confirmed the LPN had documented on the MAR the medication was given May 11, 2014, but had not observed the resident administer the drug. Medical record review of the Medication Administration Record (MAR) for May 2014, revealed the medication had been documented as given twice daily for the month of May. Interview with the resident on May 20, 2014, at 9:00 a.m., in the resident's room, with the Assistant Director of Nursing (ADON), revealed the resident had not received the medication for "some while" and had not received the medication for the month of May 2014. Interview with LPN #2 on May 20, 2014, at 9:15 a.m., at the South/West Nursing Station, confirmed when the LPN had worked the hall, the nurse had documented the medication as being given without observing the medication administered. Interview with RN Supervisor #1, at the South/West Nursing Station, on May 21, 2014, at 8:30 a.m., revealed the resident was alert and had been approved for self-administration of medications. Continued interview revealed RN #1 placed a bottle of Saline Nasal 0.65% Spray in the resident's room at the "first of the month." Continued interview confirmed the RN had signed	F 514		

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F 514	Continued From page 17 the MAR "several times" as the medication given and had not seen the medication self-administered. Further interview confirmed the medical record documentation was not accurate.	F 514		
F 515 SS=D	483.75(l)(2) RETENTION OF RESIDENT CLINICAL RECORDS Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a medical electronic record for one (#266) of thirty-seven sampled residents. The findings included: Resident #266 was admitted to the facility on November 8, 2013, with diagnoses of Care involving unspecified rehabilitation, Dysphagia, Cerebral Palsy, Muscle Weakness, and Depression. Medical record review revealed the resident was issued a thirty day discharge notice on December 18, 2013, due to non-coverage of services, and discharged home from the facility on December 20, 2013. Medical record review of the electronic health record revealed the nursing notes, facility	F 515	F 515 1. The social services director provided a written statement and included back-up documentation such as all e-mail communication and discharge summary to complete the record on 5/20/14. 2. All other medical records were in compliance. 3. Audits of completed social services notes will be completed by the director of social services weekly for 4 weeks and monthly for three months to assure completed documentation is on file. The audit results will be reported to the Director of Nursing weekly.	

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F 515	Continued From page 18 discharge notes, and all daily social services notes from December 12, 2013, to December 20, 2013, were absent. Interview with the Social Services Director on May 21, 2014, at 10:00 a.m., in the social services office, confirmed the documents were entered into the electronic health record, but those records had been lost, and per the facility information technology department's report, were not recoverable. Continued interview confirmed the resident's electronic health record was not complete and readily accessible.	F 515	4. The Director of Nursing will submit the results of the audit to the Quality Assurance Performance Improvement (QAPI) Committee consisting of the medical director, director of nursing, and at least three other staff members monthly. The QAPI committee will review the results and if deemed necessary by the committee, additional education may be provided: the process evaluated/revised and/or the audits reviewed for three months or until 100% compliance is achieved. The administrator will monitor the process to assure continued compliance.	6/25/14